Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
HCA HEALTHCARE
6000 NORTHWEST PARKWAY
SAN ANTONIO TX 78249

Carrier's Austin Representative Box
17

MFDR Date Received
AUGUST 23, 2004

Respondent Name
FEDERAL INSURANCE CO

MFDR Tracking Number
M4-04-B904-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Taken from the *Table of Disputed Services*: "Per twcc contract implants are paid at cost + 10%"

Amount in Dispute: $576.45

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated September 30, 2004: "On November 14, 2004, the Claimant underwent in-patient surgery. He remained at HCA Healthcare until November 17, 2003 – without ICU/CCU days…The surgical procedure performed required the use of implantables. The total amount billed for the implantables was $25,345 leaving a balance of $14,444.25 for the other hospital services. For the remaining non-implantable charges, 28 T.A.C. §134.401(b)(2)(A) requires a hospital to bill its usual and customary charges for the services provided. The Requestor failed to supply documentation supporting that its charges were, in fact, its usual and customary amount…The Requestor has, to date, refused to explain how it arrived at the billed amount of $14,444.25. The Requestor has failed to demonstrate that it billed its usual and customary charges for this stay, as instructed by Commission Rule 134.401(b)(2). The Requestor has not provided a cost invoice to validate its charges for the implantables, durable medical equipment, drugs and other assorted charges."

Response Submitted by: Harris & Harris, 5300 Bee Cave Road, Bldg III, Ste 200, Austin, TX 78746

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
November 14, 2003 Through November 17, 2003	Inpatient Hospital Services – Implantables Only	$576.45	$464.65

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.304, 17 *Texas Register* 1105, effective February 20, 1992,

amended effective July 15, 2000 sets out the procedures for medical payments and denials.
2. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits dated January 14, 2004
- C – NEGOTIATED CONTRACT
- * – PROVIDER INVOICE + 10%

Re-evaluation Letter dated May 26, 2004
- D – DENIAL AFTER RECONSIDERATION
- C – NEGOTIATED CONTRACT
- RE-EVALUATION
- NO ADDITONAL RECOMMENDED ALLOWANCE
- * – PROVIDER INVOICE + 10%

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. What are the requirements for reimbursement of the inpatient hospital services per 28 Texas Administrative Code §134.401?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code, "C – Negotiated Contract". Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.401(c)(4)(A)(i and ii) states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%...(i) Implantables (revenue codes 275, 276, and 278; and (ii) Orthotics and prosthetics (revenue code 274)."

3. Review of the submitted documentation the division notes that 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)." Review of the requestor's medical bills finds that the following item was billed under revenue code 0278 and is therefore eligible for separate payment under §134.401(c)(4)(A) as follows:

Rev Code	Itemized Statement Description	Cost Invoice Description	UNITS	Total Cost from Invoice	Cost + 10%
0278	DEPUY	DEPUY ACROMED	1 at $8,448.24 EACH	$8,448.24	$9,293.06
			TOTAL ALLOWABLE	*$9,293.06*	

The division concludes that the total allowable for the implantables is $9,293.06. The respondent issued payment in the amount of $8,828.41 (per EOB and DWC 60 *Table of Disputed Services*, only

implantables are in dispute). Based upon the documentation submitted, additional reimbursement in the amount of $464.65 is recommended.

Conclusion

The submitted documentation does support the reimbursement amount sought by the requestor. As a result, additional reimbursement in the amount of $464.65 is recommended.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The division hereby ORDERS the respondent to remit to the requestor the amount of $464.65 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		September 14, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.